



REGISTRATION FORM

DATE _____

SECTION I – PATIENT INFO

NAME (LAST, FIRST, MIDDLE): _____

BIRTHDATE: ____/____/____

AGE: _____

SEX: MALE FEMALE

DRIVER'S LICENSE STATE AND NO.: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

STREET ADDRESS: (PO BOX NOT ACCEPTED) _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ - _____ - _____ WORK PHONE: _____ - _____ - _____ EXTENSION: _____

CELL PHONE: _____ - _____ - _____ PAGER NUMBER: _____ - _____ - _____

****PLEASE INDICATE THE PHONE NUMBERS YOU'D LIKE US TO USE FIRST & SECOND TO CONFIRM****

EMAIL ADDRESS _____ I WOULD LIKE TO RECEIVE OFFICE UPDATES VIA EMAIL.

OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

IN CASE OF EMERGENCY, CONTACT: _____ PHONE: _____ - _____ - _____

RELATIONSHIP OF THE EMERGENCY CONTACT TO PATIENT: _____

SECTION II – REFERRAL INFO

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____



Medical History Form

(Please complete front and back of this Questionnaire)

Name: _____ **Birthdate:** _____ **Today's Date:** _____

Allergies: (List any medications you are allergic to. Also describe type of reaction you had.)

I have no allergies

I am allergic to: _____ My allergic reaction was: _____

Past Medical History: (Mark any of the following conditions you may have been diagnosed with or treated for)

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Epilepsy/convulsions | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety/panic disorder | <input type="checkbox"/> Colitis/bowel disease |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney/bladder disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Angina/chest pain | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart valve disorder | <input type="checkbox"/> Hearing disorders | <input type="checkbox"/> Genital warts |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Drug addiction |

Past surgical History: (List all surgeries you have had, including cosmetic procedures)

Year of Surgery: _____ Type of Surgery: _____

Medications: (List all medications you take regularly including prescription, over the counter and herbal medicines)

I do not take any medications

Name of medication	Dosage of medication	Number of daily doses
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations:

Have you had a Tetanus shot in the last 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Have you ever had a Pneumovax?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Have you ever had Hepatitis B vaccination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Date of last flu shot: _____			<input type="checkbox"/> I don't know



Practice Policy

A word from EB Medical Spa:

- 1. Welcome to our practice.*
- 2. We are pleased to have you here.*
- 3. Our practice mission is to provide you with exceptional care in a warm and friendly atmosphere.*
- 4. These following practice policies have been created to ensure an efficient and professional practice.*

Would you like a copy of this form? Yes, please No, thank you

 Staff initial

I _____, wish to receive services from Essential Beauty.

• *Appointments, No-shows, Cancellations, and Reschedules*

- All future appointments are booked with a booking fee of \$50 for appointments with EB Medical Spa.
- The booking fee is applied toward your appointment charges.
- You will receive a courtesy call to remind you of your appointments, but regardless of this call, showing up for your appointment is your responsibility.
- Appointments that turn into no-shows, late cancellations, or late reschedules incur considerable cost to the practice.
- Thus, the practice requires a **48-hour notice** in order to avoid a fee of no-shows, late cancellations, and late reschedules.
- This no-show, late cancellation, late reschedule fee is **\$50 for appointments with EB Medical Spa.**
- If you have paid a booking fee, the booking fee is forfeited in the case of a no-show, late cancellation, or late reschedule and will not apply toward your next appointment.

• *Payment Options*

- The practice accepts cash, check, Visa, MasterCard, American Express and Discover Card.
- All checks are run through Telecheck system.
- There is a **\$25.00 returned check fee** for any returned check not run through Telecheck.
- In case of a returned check, full payment and returned check fee must be paid in ten days to avoid dismissal from the practice and further action.

• *Cosmetic Services*

1. Full payment is required at the time of the service.
2. There are **no guarantees** as to the results of any services rendered and this practice has a **no refund policy** after services are rendered.

• *Prescriptions and Refills*

1. Dr. Chang writes all prescriptions and refills at the time of your office visit. Dr. Chang will give you enough refills to last you until he wants to see you next.
2. Thus, your refills will last you until your next appointment.
3. Should, for some reason, you need a refill in between your appointments, approval of any refill request is at the discretion of Dr. Chang.
4. There is a **medication refill fee of \$25.00** payable at the time of the request.

• *Phone Treatments*

1. At your request, Dr. Chang will offer phone treatments or phone consultations for any uncomplicated medical problems.
2. All such requests are given to Dr. Chang, and at his discretion, phone treatment or consultations may be rendered.
3. There is a **phone treatment/consultation fee of \$50.00**.

• *Privacy Policy*

1. This office follows HIPPA regulations regarding the privacy of your personal information. By signing below you acknowledge that you have been informed of this. You may request a copy of our detailed Notice of Privacy Policies.

I have read these policies and agree to follow them.

X _____
Patient/Responsible Party signature

Date